KENTUCKY STATEWIDE HEALTH REFORM DEMONSTRATION
FACT SHEET

Name of Demonstration:	Medicaid Access and Cost Containment Project
Date Submitted:	May 26, 1993
Date Approved:	December 9, 1993
Amendment Submitted:	June 22, 1995
Name of Amendment:	Kentucky Health Care Partnership Plan
Amendment Approved:	October 6, 1995
Amendment Implemented:	November 1, 1997
Extension request submitted:	March 4, 2002
Extension request approved:	October 31, 2002

BACKGROUND

The State did not have the legislation required to implement the demonstration project when it was originally awarded in 1993. As an alternative, the State submitted an amendment to the demonstration entitled the "Kentucky Health Care Partnership." The amendment proposed to divide the State into eight regional managed care networks consisting of public and private providers to deliver health care services to Medicaid beneficiaries. Each region would have one managed care entity subject to state-specified guidelines. The Medicaid beneficiaries would be enrolled into the Partnership designated for their area. In areas where a viable partnership cannot be established, the State had planned to invite two or more Managed Care Organizations (MCOs) to competitively bid for the managed care contract. The Partnership demonstration was implemented on November 1, 1997, and statewide expansion was anticipated to be complete by June 30, 1999. However, the State was never able to fully implement the demonstration beyond its two most urban areas. On July 1, 2000, one of the two operating Partnerships terminated its contract with the State leaving only one Partnership remaining in the State's largest urban area. This Partnership, which is a private non-profit entity, manages the Medicaid delivery system that includes the city of Louisville in Jefferson County and fifteen surrounding counties. This area comprises 20 percent of the State's Medicaid population. Managed care in the remainder of the State operates under authority of a 1932 (a) State Plan Option. On October 31, 2002 the demonstration was extended for an additional three years.

Second Amendment Submitted:	July 11, 2000
Second Amendment Approved:	April 27, 2001

The State submitted this amendment in response to the change in the demonstration's design from a statewide to a sub-state model. With the change to a sub-state model, the State wanted to limit its risk for budget neutrality to a sub-state as opposed to statewide basis. This amendment was approved.

Third Amendment Submitted: September 18, 2002
Third Amendment Approved: April 19, 2002

As part of the original approval, the State was granted a section 1115 waiver of cost-based reimbursement to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) repealed the cost-based payment provisions and established a new Prospective Payment System (PPS) in sections 1902(a)(15) and 1902(aa) of the Act. As outlined in the January 19, 2001, State Medicaid Director's letter, the existing waivers of FQHC cost-based reimbursement were made moot because of the BIPA provisions. The State requested waivers of the BIPA provisions to permit it to continue to apply its current payment methodology, which does not comport with the current PPS for FQHCs and RHCs. The Kentucky Primary Care Association supported this request and CMS granted the waiver.

ORGANIZATIONAL STRUCTURE

- The Partnership functions as provider-controlled managed care networks and contracts with a private health maintenance organization (HMO) to provide the necessary administrative structure (i.e. enrollment, beneficiary education, claims processing, etc).

- The Partnership is responsible for policy areas such as quality assurance, utilization management, compliance issues, and the annual evaluation of the applicant's administrator. The Partnership council consists of a coalition of providers and consumers.

ELIGIBILITY

- The state enrolls all non-institutionalized Medicaid beneficiaries including the dual eligibles into the Partnership.

- Dual eligibles must enroll in the Partnership to receive their Medicaid-only benefits such as pharmacy and transportation. They do not have to choose a primary care provider within the partnership network and retain their Medicare freedom of choice.

BENEFIT PACKAGE

- The standard Medicaid benefit package is offered to all participants. The benefit package includes: inpatient and outpatient hospital services; physician services; family planning

services and supplies; laboratory, radiology, and other diagnostic services; preventive services provided by the local health departments; home health services; and prescription drug, dental, and EPSDT services. Other services such as long-term care, mental health, school-based services are available under fee-for-service.

- All mental health services are carved out of the Partnership.

- The Partnership provides non-emergency transportation services for enrollees who require transport by stretcher only. A statewide transportation broker provides all other forms of non-emergency transportation.

ENROLLMENT/DISENROLLMENT PROCESS

- Kentucky's Department of Medical Assistance is responsible for eligibility determination. Once eligible, the beneficiaries are automatically enrolled in the partnership serving their area. Eligibility is guaranteed only for the initial six months period of eligibility.

- Kentucky's Department of Medical Assistance re-determines eligibility periodically and has the sole authority for disenrolling beneficiaries from the Partnership without recourse for the following reasons: if the member no longer resides in the service area; is deceased; is admitted to a long term care facility or correctional facility; or no longer qualifies for Medical Assistance. Beneficiary disenrollment is effective on the date specified by the State.

DELIVERY SYSTEM

- The Partnership is a coalition of medical providers from both the public and private sectors. The public sector providers include the local health departments and Federally Qualified Health Centers.

- Provider networks include hospitals, physicians, pharmacies, emergency transportation, and other providers to ensure the covered services are available within each Partnership.

QUALITY ASSURANCE

- The Partnership will make medical and other records available to the State and/or outside reviewers.

- The State is required to include in their quarterly report the reasons that beneficiaries request disenrollment.

- The State has contracted with an external quality assurance organization.

- An oversight committee, consisting of beneficiaries, consumer advocates, and public health officials, has been established to provide input.

- The State has established a toll-free hotline to respond to beneficiaries' concerns.

COST-SHARING

- There are no cost-sharing requirements.

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November 14, 2002